Watson Wyatt Worldwide

Memo

December 4, 2007

To: CalPERS Health Benefits Committee

From: Watson Wyatt Worldwide

Subject: CalPERS Unified Health and Disease Management Program

Summary

Watson Wyatt Worldwide was asked to provide an opinion on Staff's proposed unified health and disease management initiative for CalPERS.

Overall Opinion

We support the concept of a comprehensive, integrated, evidence-based health and disease management program consistently implemented across the entire CalPERS' population and we concur with Staff that this initiative, properly designed and executed, could favorably impact member health and benefit plan costs and position CalPERS internationally as a world-class innovator.

However, we advise that substantial work still remains to achieve a best practice design and a tactical implementation plan that addresses CalPERS' 5 Year strategic plan and industry best practices in the context of a somewhat complex environmental situation, which includes multiple related, and potentially synergistic, health initiatives (single administrator, data warehouse, member engagement). Therefore, we would like to make a few brief observations and recommendations, recognizing that given the relatively short time frames involved in the review, we may not have complete information.

Basis of Opinion

Our opinion and findings are based on a review of the following CalPERS' documents:

- October 16, 2007 Board Meeting Minutes;
- July 27, 2007 Mercer presentation "Health & Disease Management: An Approach for CalPERS";
- CalPERS_HBC Member Orientation Manual_as of 110906.

Recommendations

1. Staff should prepare a tactical implementation plan that identifies priorities, addresses contingencies of all current and planned health benefit initiatives, and provides for regular transparent milestone reports to the Board.
   As currently proposed, the unified health and disease management approach is a generic, high-level strategy that is comprehensive in scope and demonstrates a logical flow from data analysis, to program selection and design, to measuring results. The program intends to deliver a seamless experience for members with best practice programs and services across the health continuum of the population while providing transparent monitoring and continuous process improvement. Staff proposes to accomplish this by successfully engaging stakeholders, driving results through integration, and leveraging information technologies. If properly designed and executed, this initiative is aligned well with CalPERS' strategic plan and would contribute towards several strategic goals, including "top box" member satisfaction, implementation of incentives for healthier lifestyles, measurably improving lifestyle behavioral change, enabling members with chronic disease to better manage their condition, and quality and performance goals for provider networks.

   Note: we understand that an implementation plan, incorporating all current initiatives, is either under development or completed, but have not had an opportunity to review that plan.

2. Mapping and prioritizing the key integration points across crucial domains at a granular level, aligning with other health initiatives (e.g. HCDSS, single administrator, and value-based benefit design), and customizing the overall strategy to CalPERS' situation are critical success factors for the health and disease management initiative.

   Comprehensive, integrated health and productivity (H&P) programs are clearly an industry best practice that drives financial performance. In a recent survey of 355 large employers, the Watson Wyatt/NBGH 2007/2008 Staying@Work Report "Building an Effective Health & Productivity Framework" found that plan sponsors with highly effective H&P programs were four times as likely to report lower benefit cost trends as low-effectiveness peers. For best results, H&P programs must be integrated in three domains:
   - Measurement - data and reporting;
   - Programs - design and delivery;
   - Engagement - incentives, organizational alignment and communications;

   and at several levels:
   - organizational,
   - provider,
   - member

For example, in the Staying@Work Survey, high-effectiveness organizations were more likely to integrate data from all programs and a variety of sources, including lifestyle-related risks, preventive care, disease management, disability, and absence data. High performers were also more than three times as likely to integrate health management programs through a single-access-point technology platform and more than twice as likely to use health coaching for lifestyle behavioral change, triage of acute care, and management of chronic disease. Finally, these successful organizations invariably used H&P planning as part of health benefit planning, as a tactic for improving business results, and connected H&P programs to broader organizational initiatives. Mapping and prioritizing the key integration points across these domains at a granular level, aligning with other health initiatives (e.g. HCDSS, single administrator, and value-based benefit design), and customizing the overall strategy to CalPERS' strategic situation are critical success factors for the health and disease management initiative. This customization is especially important since disability and absence management – typically success factors in an H&P program -- are not explicitly a part of CalPERS' responsibility to its members and member agencies.

3. The role of quality of care metrics and related program strategies (e.g. Centers of Expertise, Telemedicine, and Health Advocacy) as an integrated part of the unified health and disease management initiative should be further developed by Staff.

   Staff is currently developing a set of health and disease management measures that can or will be reported from HCDSS. They are also working with the health plans to develop the processes necessary to report, capture and analyze these measures with the intent of ensuring best practice performance of health programs. This measurement component appears (rightfully so) to be a high priority for Staff and is a necessary first step to enable the data analysis for program design and consistent performance evaluation across the population continuum. Design and implementation of HCDSS is a critical success factor for transparent, timely reporting of program performance to all stakeholders, including the Board, and we have provided specific observations and recommendations for HCDSS in a separate opinion letter. In addition to value-based plan design decisions and segmentation of the health risks and cost drivers of the population, HCDSS could also be leveraged to improve quality of care for members through the unified health and disease management program. In the Staying@Work Report cited earlier, we note that organizations with the most effective health and productivity programs are over three times as likely to actively market quality tools for provider selection and evaluation. Unwarranted geographic variations in health care and inappropriate use of services and procedures (overuse, underuse, misuse) clearly impact costs and the health outcomes of member. However, health advocacy (e.g. navigation of the health care system, fighting for legitimate coverage of denied care, problems with misdiagnoses, claim resolution) is not clearly articulated as a component of the overall strategy proposed by Staff. It is not clear how inappropriate use of emergency room and primary care for minor, self-limiting conditions (likely a significant waste of resources at CalPERS leading to unnecessary prescriptions, tests

and follow-up visits) will be mitigated under the proposed strategy.

4. The feasibility of carving out some or all of the health and disease management programs from the health plans and the specific role of the single administrator in health and disease management should be carefully evaluated in light of the stated goal of establishing consistency and improving performance across plans and creating a seamless experience for members.

   Successful execution of integrated best practice programs requires careful delineation of the challenges and opportunities of the relevant strategic alternatives available to CalPERS. For instance, the proposed plan appears to tacitly assume that the health plans can deliver high quality, consistent, uniform, integrated services that produce results--an assumption that has little basis in evidence. Compared to "best-in-class" independent vendors, health plans generally have modest experience in health and disease management with insufficient proof of impact. Furthermore, many health plans are unable to deliver a fully integrated solution because they struggle with legacy IT platforms and organizational integration of recent health management vendor acquisitions that result in fragmentation and silos. Finally, health plans can only manage and report on their members, which is a fraction of CalPERS' population. Carving out this initiative to a single health and disease management vendor would eliminate some of these gaps, but would still require significant integration effort of provider networks, plan design, and other health plan functions with the program. An alternative hybrid approach to the "carve-in" health plan programs or the "carve-out" approach would be to develop a unified CalPERS' health and disease management model with compulsory program best practices and metrics against which all vendors would be required to perform. The pros and cons of carving out some or all of the health and disease management programs from the health plans and the specific role of the single administrator in health and disease management should be carefully considered in light of the stated goal of establishing consistency and improving performance across plans and creating a seamless experience for members.

5. Integrating physician practice at the point-of-care into a unified CalPERS' health and disease management program should be considered by Staff as an emerging best practice**.**

   Best practice programs are not only integrated across the three domains of measurement, programs, and engagement, but also at the level of the member and physician, where health care is co-produced. It is critical to avoid a disease silo approach to health improvement which assumes a traditional division of programs instead of a "whole person" approach to health and disease management. In designing such programs, the diversity of the CalPERS' beneficiary population must be adequately addressed so that communications and program interventions are personalized for each member. Just as importantly, programs must competently

coordinate the care plan for multiple co-morbidities, especially between physical illnesses and mental illnesses such as depression, substance abuse and stress.

Looking to the Future

CalPERS seeks to develop an innovative set of programs and practices that establishes new benchmarks in the industry. One of these emerging trends in health and disease management is the re-emergence of primary care and incorporation of the Chronic Care Model (originally formulated by Wagner) as a core element of health management program design and execution. Elements of this model include:

- Linking physician offices with community and benefit resources
- Organizing and redesigning the health care delivery system
- Empowering consumers and supporting self-management with appropriate tools and resources
- Redesigning clinical work processes to eliminate unnecessary steps, automate where possible, delegate care to less expensive team members
- Implementing point-of-care decision support for patients and physicians
- Leveraging clinical information systems with reminders, treatment goals, gaps reports, and performance metrics

Earlier this year The Centers for Medicare & Medicaid Services announced the first year results of the three-year Medicare Physician Group Practice (PGP) Demonstration, a physician-based care management model that rewards providers for coordinating and managing the overall health care needs of Medicare patients with chronic conditions. All 10 participating physician groups improved the clinical management of diabetes patients on at least 7 of 10 quality measures and a majority of the participating physician groups lowered Medicare cost trends compared to their market. The first year performance of this PGP model contrasts dramatically with the results of several large, well-designed demonstration projects testing call center-based care management model employed by national DM vendors. Most of the national DM vendors in these demonstration projects have not shown a significant impact on cost or quality outcomes and many struggled with contacting and engaging beneficiaries in their programs.

Another emerging best practice is an emphasis on primary care in designing benefit plan co-pays, provider reimbursement strategies, and disease management programs. A number of national health plans and large employers are piloting "Medical Home" initiatives to improve the care of patients, especially those with chronic disease. Principles of Medical Homes, as articulated by AAFP, AAP, ACP include:

- An ongoing relationship with a personal physician
- The personal physician leads a team of clinicians at the practice level
- Whole-person orientation to care

- Access to care is enhanced through multiple portals of communication, open scheduling, etc
- Quality improvement and safety are hallmarks of care
- Payment for services appropriately recognizes the added value provided by a patient-centered medical home

The interest in primary care is anchored in a large body of literature and international experience that demonstrates that larger ratios of primary care providers in a population are correlated with lower cost and higher quality outcomes.

Kirby G. Bosley

West Division Practice Leader
Group and HealthCare

Darryl Landis, MD

Michael Wood
Sr. Consultant
Group and HealthCare